Code Correlations: Patient Status Codes

Medi-Cal has developed administrative code set correlation tables for provider use to begin to prepare for business and billing operation changes, software and practice management system modification and vendor or clearinghouse use. Additional policy, billing instructions and provider manual replacement pages will be included in future *Medi-Cal Updates*. These correlation tables are separated by claim type and billing media (paper, current proprietary and non-standard formats as well as the HIPAA standard formats). These values are not to be used for billing purposes for dates of service prior to September 22, 2003. The correlation tables apply to both paper and electronic claims submission, with each billing medium and table being represented separately. The table for this code set applies to the following billing media:

- Inpatient Paper Claims (UB-92)
- Version 4 Flat File
- CMC Proprietary (CMC 03)
- ANSI ASC X12N 837 version 3041
- ANSI ASC X12N 837I version 4010A1

Modifications for billing:

- Paper: Field Locator (FL) 22 – Patient Status
- Version 4 Flat File: Record Type 20, Field 21 – Patient Status
- CMC Proprietary: Patient Status
- ANSI ASC X12 837 version 3041: Loop 2300, CL103 – Patient Status
- ANSI ASC X12 837 version 3041: Loop 2300, CL103 – Patient Status

Billing information:

- Long Term Care interim (local) patient status codes will be converted to national patient status codes after October 2003. Until instructed otherwise, continue to use the interim (local) patient status code values.
- Claims currently required to be billed on paper are still required to be billed on paper at this time.
- The following correlation shows the national value for this field to be used when completing a claim with a beginning date of service on or after September 22, 2003.
- When completing a claim with a beginning date of service before September 22, 2003, the current Medi-Cal code must be used.
- The following correlation is in Medi-Cal current code value order.

PATIENT STATUS CODES			
CURRENT VALUE	DESCRIPTION	NATIONAL VALUE	DESCRIPTION
01	Discharged to Home or self care (routine discharge)	01	Discharged to home or self care (routine discharge)
02	Discharged/transferred to another short term general hospital for inpatient care	02	Discharged/transferred to another short-term general hospital for inpatient care

PATIENT STATUS CODES			
CURRENT VALUE	DESCRIPTION	NATIONAL VALUE	DESCRIPTION
03	Discharged/transferred to Skilled Nursing Facility	03	Discharged/transferred to Skilled Nursing Facility (SNF)
		61	Discharged/transferred within this institution to hospital based Medicare approved swing bed
		64	Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare
04	Discharged/transferred to an Intermediate Care Facility	04	Discharged/transferred to an intermediate care facility (ICF)
20	Expired	20	Expired
30*	Still a patient or expected to return for outpatient services	30	Still a patient
31*	Admitted (first interim bill)	31	Still patient to be defined at state level, if necessary

***** Enter "31" to identify patients still admitted at the end of the billing period. Code "31" is used on the first interim billed. Use code 30 for subsequent billing

Bolded items denote changes to previously used values.